DISCUSSION OF PUBLIC-PRIVATE PARTNERSHIP: ITS INFLUENCE UPON OFFICIAL AND NONOFFICIAL HEALTH AGENCIES*

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DR. JOSEPH T. ENGLISH, in whose place I speak on this occasion, has asked me to give you his deepest apologies for not being able to be here today. He had looked forward with considerable anticipation to attending, but at the last minute he was called to a meeting at which no substitutions were permitted, and that is where he is.

I must say that I am happy to be here. I am reasonably new in New York City, and I feel somewhat like the new bride who, while being carried across the threshold on her honeymoon said, "Boy, I'm awful nervous, but I've sure been looking forward to being here."

I shall try to fill in for Dr. English. Of course it is impossible for me to do so completely. The best I can do is give you an unbiased report of what he might have said, from my point of view.

I agreed with E. Richard Weinerman yesterday afternoon when he surmised that we may have adequate resources in this country already but that perhaps we need to utilize them better. I think that this is where planning for health should begin and that this is its goal: to allocate better and to use better what we now have rather than to spend too much time dreaming up new panaceas.

We have talked a good deal about funding mechanisms that the federal government has provided over the past few years. Many believed that the principal barrier to good health care was financial, and that if everyone were given sufficient money, everyone would receive all the care he needed.

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As a result of this, the laws we have discussed in the last few days have come into existence and have provided millions of dollars for millions of people to pay for care which they could not afford otherwise. This money has placed great stress on the capacity of the American health enterprise. Increased numbers of patients have made it increasingly difficult for doctors and health-care institutions to maintain high standards of quality.

The increased demand imposed on a relatively static and limited supply of health resources has produced strong inflationary pressures; hence costs have shot upward. In short, we have found that issuing money tickets into the health system, while necessary, is by no means the complete solution of the problem. In addition to this financing of programs what we need is a really concerted effort to build the capacity of our health resources so that they can respond to a challenge of this magnitude.

Moreover, because of the particularly personal and local character of medical care, this national effort must have its impact in the communities, where the doctors and the hospitals are facing daily the demands of serving more people than ever before. In many of the recent programs the federal government has attempted to strengthen these local community health capacities and capabilities. We do not need to review them since they have been reviewed previously. It suffices to mention the Hill-Burton Act and all the various manpower expenditures of the National Institutes of Health and of the Department of Labor.

I still maintain that the most critical and immediate need is to make better use of the resources that are already available. Several programs, most of them of recent origin, are under way which have the purpose of strengthening and improving the organization of health care. These are programs we have just discussed—the Neighborhood Health Centers of the Office of Economic Opportunity, maternal and child health programs of the Children's Bureau, and the projects under Partnership for Health: planning projects aimed at immediate accessibility of health care in neighborhoods.

As you know, these involve a variety of health institutions and agencies in deploying existing resources in new patterns rather than in creating new resources. The Community Mental Health Centers program is bringing the treatment of mental illness out of remote isolation

and into the community range. It also prevents mental illness in a number of highly significant ways. The regional medical programs draw existing resources together in new relations in order to enable physicians to provide the best in modern care.

The migrant health program augments the community capacity to serve a group whose health needs heretofore have been beyond the reach of any existing community program. All these should be viewed as sources of strength on which the community can draw, singly or in combination, according to its own needs and priorities. The synthesis of these community-target efforts must take place in the community if the work is to be truly meaningful in terms of real medical care delivered to individuals and to their families.

Thus I feel that the common federal and state task is to facilitate that synthesis in every possible way. And again I feel that the one important way to encourage and support this process is under a partnership for health: the planning processes whereby states and communities can arrive at rational assessments of need and priority.

We are not talking about facilities alone: we are talking about services to people. We are not only talking about personal health services but we are talking about environmental health services; and we are talking about housing, transportation, and economic factors that affect health. Of course this planning activity is merely beginning, and it is having problems. It should have problems, because it is a tall order.

The issues are very complex but I do not believe we can ignore them. I think that our procedure in these partnerships—local, state, federal, private, voluntary—is to break down some of the old ways of thinking; to break down the old attitudes we have maintained for years, categorical attitudes, attitudes of self interest; and recognize that the aspirations of people in their communities for health, in all these aspects, far exceed the resources available to produce everything they want.

Therefore we must look at these limited resources and identify the ways in which they can be used most effectively regardless of their source, whether they are derived from local taxes or collected in a yearly fund drive, or from pocketbooks, or from insurance companies, or whether they come from state and federal funds. We must look at the over-all problem and design ways in which these mixed and limited resources will give the best yield to meet the health problems of the community.

More important, if we wish to keep our planning relevant and realistically oriented to live issues we must be on guard against forming a conspiracy to keep people from doing something about health. It seems clear to me that no single partnership or set of intergovernmental arrangements can possibly govern the improvement of the health-care system. We cannot decide, for a number of compelling reasons, that all federal involvement in health will proceed through one political channel. There is no one rain god.

Block grants surely have their role, but we cannot mandate that every governor and every legislature simultaneously and uniformly undertake the full range of challenges involved in the delivery of health care. Other enterprises must be engaged: physicians, medical societies, hospitals, insurance carriers, and a myriad of interrelated activities of which Bernard Bucove has spoken. We may cite Model City programs as a single example.

What we must strive to do in New York City, in Albany, and in Washington is to encourage not one partnership but many. The test of our political genius will be whether all the partnerships can work. Those who are charmed by the abstract simplicity of a nice tidy pyramidal relation in planning for health just do not reckon with the complexity of the system of health care.

I find myself somewhat impatient with those who expect that a system of total national health care in which all the pieces interconnect very neatly can issue full-blown as the result of a single planning structure, process, or plan. I understand and share the impatience, but I find myself impatient also with those who too loudly lament the lack of instant visible progress—only two years after the enactment of the Partnership for Health legislation, or three years after the Regional Medical Programs.

What we are tackling in health care is one of the most complicated experiments in intergovernmental, interprofessional, and private-public relations undertaken in this country's history. Moreover, we are tackling it at a time of constraints in resources which make hard choices harder. The real test will come in our communities and in our professions. Can we adjust our individual aspirations and fit them into the larger social setting? Can we combat effectively the tendency of institutional arthritis to stiffen both society and government?

As we think of the magnitude and the complexity of the problems

before us, perhaps we can take heart from some words of Winston Churchill. When he was asked in late 1941 how long it would take to beat the Axis powers, he thought for a moment and he said: "Well if we plan it well, it will only take half as long as if we plan it badly."

I trust that we shall all work, in whatever partnerships, to plan well and manage well these new partnerships on which we are embarking.